Chapter Five

Other Considerations

The Managed Competition Act of 1993 proposes to restructure the health care system using market reforms, competitive forces, and subsidies for low-income families to expand health care coverage and slow the rate of growth of health spending. Changes in the tax system would make people with employment-based coverage more sensitive to its price, as well as provide incentives for uninsured people to purchase coverage. The proposal would not require people to obtain health insurance, but under it the number of uninsured people would drop significantly.

To strengthen the demand side of the insurance marketplace, employees of small firms and people without ties to the labor force would purchase health care coverage through regional health plan purchasing cooperatives (HPPCs), which would offer a choice of accountable health plans (AHPs). All AHPs would provide coverage for a standard package of benefits that would be specified by a federal Health Care Standards Commission. Consequently, purchasers would base their choices on price, quality, and convenience. Within the HPPC, a modified form of community rating would prevail that would ensure that a plan's premiums would vary only by type of enrollment (individual, individual and spouse, individual and one child, and individual and family) and the age of the principal enrollee. All people, regardless of their actuarial risk status, would be assured that they could obtain coverage.

All employers would have to offer their employees health insurance coverage through an AHP, but they would be under no obligation to contribute to the cost of that coverage. Small employers could meet this requirement only by contracting with a HPPC. Large employers would have more flexibility; they could self-insure by establishing an AHP for their employees or purchase coverage in the marketplace from an insurance carrier offering AHPs, but they would be prohibited from purchasing coverage through the HPPC. Large employers would, however, have to ensure that their employees were at no financial disadvantage from being outside the HPPC; generally, one of the plans that they offered would have to provide coverage at a cost to their employees that was no higher than the reference premium for their area (that is, the premium for the lowest-cost plan in the HPPC that enrolled a specified proportion of the eligible population).

The proposal would terminate the Medicaid program and provide federal subsidies to low-income families to enable them to purchase health care coverage from plans of their choice, either through the HPPC or, in the case of low-income families with a worker employed by a large firm, from their employer. The subsidy program would not be open ended; federal expenditures for subsidies would be limited to the savings and increased receipts generated by the proposal. Although the federal liability for subsidies would be effectively capped, the Congressional Budget Office (CBO) believes that if the shortfall in subsidies was substantial, the mechanism for limiting the federal subsidies would seriously disrupt the insurance marketplace and could render it unworkable.

Even with subsidies for low-income people, this voluntary system of health care coverage would still leave a significant number of people uninsured. Although premiums would be community rated,

they might still represent a considerable bite out of the budgets of those low- and moderate-income families who were eligible for, at most, a partial subsidy. Nevertheless, proponents of the managed competition approach believe that the market system should be given an opportunity to work before mandates on individuals are considered.

As with other proposals that would fundamentally restructure the health care system, estimates of the cost and other consequences of the Managed Competition Act are highly uncertain. One reason for this is that managed competition remains a largely untried system, and there is little analytical evidence to indicate how effective it might be. Although a few large purchasers of health insurance have implemented components of the managed competition approach, and voluntary purchasing cooperatives exist in some markets, these experiments offer little insight because they operate in a larger environment that is unmanaged. The ramifications of the proposal are also uncertain because important features--including the standard benefit package and many operational details--are not specified and would be left for the Health Care Standards Commission, the Congress, or later regulations to resolve.

In preparing its cost estimates, therefore, CBO had to make a number of assumptions about both the effectiveness of managed competition and the unspecified dimensions of the proposal. Several of the underlying assumptions were difficult to develop and, together with other uncertainties about the proposal, gave rise to fundamental questions about how the system would actually work. This chapter discusses several of these issues.

Determining Eligibility for Subsidies

As described in Chapter 1, the Managed Competition Act would establish a complex system of subsidies that would be a challenge for the Health Care Standards Commission to administer and for beneficiaries to cope with. Subsidies for premiums and cost sharing would be available for non-Medicare enrollees with family income below 200 percent of the poverty level. Medicare beneficiaries with income below 120 percent of the poverty level would be eligible for premium subsidies; those with income below 100 percent of poverty would also be eligible for cost-sharing subsidies. People with income below the poverty level would also be entitled to federally financed wraparound benefits--services that are now covered by Medicaid but would not be included in the standard benefit package promulgated by the commission. All those receiving Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) would be eligible for full premium and cost-sharing subsidies as well as the wraparound benefits, regardless of whether their family income was below the poverty line. Although, in principle, the eligibility criteria are straightforward, several questions arise about the feasibility and possible consequences of the system for establishing eligibility.

State-Adjusted Measures of Poverty

The proposal does not adopt the usual approach to means-tested programs, which is to employ a national poverty standard. Rather, it would use state-specific measures in an attempt to adjust the eligibility criteria for the wide variations in the cost of living across the country. The goal of this approach is to target subsidies more effectively toward the neediest people. Although this goal has obvious appeal, it is not clear whether it could be accomplished. Cost-of-living indices for states do not exist, and the Departments of Labor and Commerce would have to undertake a major statistical effort to generate reliable indices. Consequently, CBO was unable to take such adjustments into account in its cost estimates.

Even if reliable indices could be developed, using state-specific measures of poverty could create considerable confusion in the many multistate urban markets in which eligibility for a subsidy would vary according to the jurisdiction in which one lived (assuming that eligibility was based on one's state of residence rather than place of employment). The variation in eligibility criteria could cause low-income families to cluster in certain border jurisdictions. In addition, the commission's job would be made more difficult if it had to calculate subsidies

based on more than 50 separate poverty levels. In the end, switching to state-specific measures might result in only modest improvements in the targeting of subsidies, because variation in the cost of living within states could be as great as that between states.

The Eligibility Process and Access to Care

With the exception of AFDC and SSI beneficiaries, who would automatically be eligible for subsidies, low-income people might find the process of obtaining subsidies rather daunting. They would have to apply to a federal agency--the Health Care Standards Commission--submitting proper information about their family circumstances, income, employer, and the AHP in which they were enrolled or wished to enroll. Those receiving subsidies would have to reapply for them each year in October to be eligible for subsidies for the following year; if their income fell during the year, they could apply for larger subsidies at quarterly intervals. If they failed to file an annual income reconciliation statement in April, they would lose their eligibility for future subsidies.

How accessible would this system of subsidies be to low-income people, particularly those with limited education, complex family circumstances, unstable income, and a high degree of residential mobility? The proposal provides some assistance for local organizations to help people apply for subsidies, but the appropriation for these activities would be small. State and local governments would have no explicit role in this process, although they probably would facilitate enrollment in order to avoid costs they would otherwise incur for uncompensated care. If adequate outreach and assistance were not provided, many low-income families might remain uninsured and not seek to enroll in health plans until they needed medical care. Yet many of these uninsured people might find that they could not enroll in AHPs at the particular time they needed care because, unlike enrollment in the Medicaid program, which is year-round, enrollment in AHPs would be restricted to an annual 30-day open-enrollment period. (Special enrollment periods would be available for people who experienced changes in family or employment status.)

Thus, although the proposal would allow many low-income families to purchase health insurance in a systematic or planned way, it would also remove the ready--or "as needed"--access to coverage that Medicaid affords to eligible populations. This change could leave the providers of last resort that serve the low-income population--hospital emergency rooms, outpatient departments, and public clinics--in difficult circumstances. Some could experience an increase in uncompensated care.

The Potential for Overpaying Subsidies

The methods that the proposal specifies for determining eligibility for subsidies and distributing subsidies to AHPs also raise the possibility that subsidies might be misdirected or overpaid. The Health Care Standards Commission would establish the eligibility of individuals and then send premium and cost-sharing subsidies directly to their chosen plan. Thus, AHPs enrolling low-income people would receive subsidy payments from the federal government with relatively little ongoing federal monitoring of the process. Verification would be performed for only a sample of those receiving subsidies.

The proposal specifies an annual process for reconciling the premium subsidies by comparing actual with expected income using data from the tax system, although many of those eligible for subsidies would not be required to file tax returns and would therefore have to file a separate income statement with the commission. There would be no reconciliation for the cost-sharing subsidies or the wraparound benefits for low-income people. Apparently, AHPs would have no liability for repaying any excess subsidy payments that they might receive.

Because of the constant movement of people in and out of HPPC areas, their changing eligibility for subsidies, and the fact that some people would probably be dropped from health plans if they did not pay their share of the premium, it would be difficult for the commission to avoid misdirecting some subsidy payments. To minimize the extent of that problem, it would need to track the enrollment and disenrollment records of low-income individu-

als and their eligibility for subsidies very closely--probably on a quarterly basis. The commission would also have to make the subsidy payments that frequently; the probability of overpayment would increase considerably if subsidies were paid annually or even semiannually.

The Consequences of Shortfalls in Payments for Low-Income Enrollees

The complex subsidy mechanism that would be created by the Managed Competition Act and the controls that would be established to ensure that the subsidies did not add to the federal deficit could present AHPs with shortfalls in payments for low-income enrollees and considerable amounts of uncertainty that could undermine the effective functioning of the HPPC marketplace.

Shortfalls in premiums for low-income enrollees could arise from the limits that the proposal would place on federal subsidies. The annual amount available for subsidies would be limited to the sum of any additional revenues generated by the tax changes in the proposal and the savings from eliminating the Medicaid program, reducing spending for Medicare, and prefunding retiree health benefits in the Postal Service. This pool of resources would finance premium and cost-sharing subsidies, wrap-around benefits for low-income people, transition assistance for the states (between 1995 and 1998) as they took over the long-term care portion of the Medicaid program, and other grants and expenditures included in the proposal.

The premium subsidies for non-Medicare enrollees, however, would be paid only after all of the other required payments had been made; hence, these subsidies would bear the brunt of any shortfall. If the available funding was insufficient, AHPs would have to accept reduced premiums for their low-income enrollees. Moreover, even with full funding of the subsidies, some AHPs could experience shortfalls in premiums and cost-sharing payments for low-income enrollees.

If shortfalls in payments for low-income enrollees occurred--for whatever reason--AHPs would probably have to raise their premiums for all enrollees. Although the proposal includes provisions to distribute the burden of premium and cost-sharing shortfalls across all health plans (including closed AHPs) and across HPPCs, it would be extremely difficult to develop and implement an accurate and effective distribution mechanism. Consequently, the approach to subsidizing the health care coverage of low-income people--which is an explicit form of cost shifting--could introduce considerable uncertainty and instability into HPPC markets. Moreover, if shortfalls were substantial, the amount of cost shifting that would be necessary to cover them might be untenable.

Shortfalls in Premiums

In general, AHPs enrolling low-income people would experience shortfalls in premiums if federal subsidies were not fully funded. In that case, AHPs would be required to cut their premiums for low-income people and absorb the difference themselves (see the appendix). Because any subsidy would be inversely related to a family's income--reaching zero for those at 200 percent of the poverty level--the corresponding premium shortfall would decline as income rose above poverty. Even if the unspecified mechanism for distributing the shortfalls among health plans worked perfectly, AHPs would have to raise premiums for all enrollees to cover the average systemwide shortfall. If the distribution mechanism was not perfect, AHPs would have to raise their premiums by differential amounts to cover their particular shortfalls. That response could change AHP premium rankings within a HPPC, possibly changing which AHP was the reference plan (the lowest-cost plan enrolling a specified proportion of the eligible enrollees).

The only situation in which an AHP might not experience a shortfall with partial funding of federal subsidies would be if a low-income person received an employer's contribution for the entire premium. Although the proposal is silent on what would happen if an employer contributed more than the maximum premium that an AHP could charge a low-income person, it would be illogical to ask a plan to accept a lower payment in those circumstances. In general, however, the primary beneficiary of employers' contributions would be the federal government, which would reduce its premium subsidy

accordingly. Given that employees "pay" for their employers' contributions to health insurance through lower wages, every dollar from an employer that substituted for a federal subsidy dollar would make low-income workers worse off.

Even with full funding of the subsidies, AHPs with premiums higher than the reference premium would have to lower them for low-income enrollees. The amount of the reduction would be a function of the family's income and the degree to which a plan's premium exceeded the reference premium. For example, a poor family participating in a higher-cost plan would be required to pay only 10 percent of the difference between the reference premium and the plan's actual premium. There would be no federal subsidy to cover this shortfall because the maximum subsidy could not exceed the reference premium. If, in addition, the federal subsidies were only partially funded, the plan would face a higher premium reduction--reflecting both effects.

It is not at all clear how many low-income families would choose to enroll in plans that charged more than the reference premium. Much would depend on the distribution of premiums among AHPs in the HPPC area, the availability and accessibility of plans that cost no more than the reference premium, the perceived quality of care in such plans, total out-of-pocket premium costs, and the additional out-of-pocket premium costs associated with the higher-cost plans. Families with income around the poverty level, particularly those with health problems, might find the higher-cost plans an attractive option because at that level of income they would be required to pay little out of pocket to enroll. By contrast, families with income in the declining-subsidy range might be discouraged from purchasing any insurance (either at the level of the reference premium or higher) because of the substantial individual obligation they would face.

Shortfalls in Cost-Sharing Subsidies

All AHPs would be required to lower cost-sharing amounts to "nominal" levels for non-Medicare beneficiaries with income less than 200 percent of the poverty level. Under the proposal, plans would receive cost-sharing subsidies that would not be tied to the actual health care expenditures of their low-income enrollees. Rather, the cost-sharing subsidies would be lump-sum payments that would vary only by the type of enrollment and the age of the principal enrollee.

These payments would be uniform nationwide and consequently could vary widely as a percentage of total costs in different markets. Some plans could gain and others lose under such an arrangement, depending on the utilization patterns of their enrollees. Moreover, there is no guarantee that reductions in cost sharing would be fully subsidized in the aggregate, since the Health Care Standards Commission would allocate the annual funds for cost sharing in advance based on estimates that could be far off the mark, especially in the initial years of implementation.

The Interplan Reconciliation Process

To ensure that AHPs enrolling large numbers of low-income people would not be disproportionately affected by shortfalls in subsidies or premiums, all AHPs--including self-insured firms--would be required to participate in a nationwide system that would distribute reductions in premiums and cost sharing equitably among plans. Developing a national transfer system involving the thousands of AHPs in the country would be an extremely difficult task, and whether it could be implemented effectively is doubtful.

The proposal does not spell out the principles on which the transfers would be based. Would, for example, plans with higher premiums be entitled to receive larger interplan transfer amounts for subsidized enrollees than plans with lower premiums in markets with the same reference premium? Certainly, the shortfalls in premiums would be greater for the higher-cost plans, but requiring other plans to contribute more in consequence raises the possibility that unsubsidized enrollees in low-cost health plans would have to pay higher premiums to help subsidize low-income enrollees in higher-cost plans.

A further complexity for the transfer system is that reference premiums could vary greatly among

HPPCs, reflecting differences in input costs, practice patterns, quality of care, competitiveness of the marketplace, and the efficiency with which health care was delivered. Because federal subsidies in any HPPC area would be tied to the reference premium, plans in markets with high reference premiums would receive larger subsidies than plans in markets with low reference premiums. Questions would inevitably arise about whether such discrepancies could be justified or whether they were unfair to health plans in highly competitive markets.

Conceptual questions such as these are difficult to address and would be politically charged. They also evoke concerns about equity among individuals, plans, and geographic areas and may not be appropriate issues for an appointed commission to resolve.

The Effects of Shortfalls on Insurance Markets

The proposal's complex subsidy mechanisms would introduce a good deal of uncertainty and instability into HPPC and non-HPPC insurance markets. AHPs would have to estimate their potential shortfalls under a number of circumstances in order to set their premiums. These calculations would be extremely complex because each plan's expected shortfall would be related to a number of factors that would be difficult to predict, including:

- The federal premium subsidy percentage for the year;
- The relationship of the plan's premium to the reference premium and to the premiums of other plans in the market;
- The number of low-income families who might enroll in the plan by type of enrollment, age of principal enrollee, and family income as a percentage of the poverty level;
- The amount to be received for cost-sharing subsidies relative to the use of services by eligible enrollees;
- The effectiveness of the mechanism for adjusting premiums for risk within the HPPC; and
- The amount that the plan might receive through the interplan reconciliation process.

The estimating process would have to be a dynamic one because a plan's anticipated shortfall would be related to the level of its premium. A higher premium would probably change the relationship of the plan's premium to the reference premium, which would itself depend on the final decisions made by all the plans. A higher premium would also cause some enrollees to drop their coverage or switch plans. Those that dropped coverage might be healthier than average, causing the average level of risk of the plan's enrollees to rise and placing further pressure on premiums. Thus, when setting premiums, plans would find themselves dealing with many unknown and interdependent variables.

Determining premiums would not become less complex or more certain over time. The federal subsidy percentage could vary from year to year; the reference premium in the HPPC would probably change annually, as might the plan or plans offering that rate; and considerable numbers of people--particularly low-income people--could switch plans each year to minimize their out-of-pocket premium payments. In short, the premiums of health plans in HPPCs with a high percentage of low-income enrollees could be unstable and unpredictable.

In the absence of an effective distribution process, AHPs might respond in a variety of ways to shortfalls in payments. The responses and their impacts would generally be greater within the HPPC than outside it because low-income people would constitute a much higher proportion of the HPPC population. Once a plan had set its premiums for the year, it presumably could not change them until the following year. Consequently, if the projection of the shortfall in payments for low-income enrollees on which the premium was based turned out to be too low, a plan could not adjust its premiums to compensate in the short run. Small shortfalls would probably pose little problem. Large shortfalls, however, might produce various interim responses, such

as lowering payments to providers and reducing the quality or quantity of care provided.

In the longer term, plans faced with significant reductions in payments would almost certainly raise their premiums; some might even withdraw from the market. If people chose to drop their coverage when premiums rose, the consequences would not be confined to the plans immediately affected. Because enrollment in AHPs would be voluntary, some healthier people might drop out of the HPPC market altogether rather than just switch plans. This response would cause the average risk level of all enrollees in the HPPC to rise, potentially resulting in an upward spiral of premiums in the HPPC. Very large shortfalls in premiums could cause the HPPC system to collapse entirely because the amount that AHPs would have to pass on in higher premiums would be unacceptable. CBO believes that to avoid such consequences, the subsidies would have to be close to or fully funded.

The Tension Between Covered Benefits and the Proposed System of Subsidies

CBO's analysis suggests that it would not be possible to implement the proposed system of subsidies in conjunction with a relatively generous benefit package, full funding of the federal subsidies, and no increase in the federal budget deficit. The available funding for the proposed subsidy pool would be insufficient.

If the commission established a standard package of benefits that was similar to that required by the Administration's proposal--which is about 5 percent more generous than the average employer-sponsored plan--the annual shortfalls for premium subsidies for the non-Medicare population would average over 30 percent between 1996 and 2000. If such shortfalls were reflected in reduced premium subsidies, they could well jeopardize the orderly functioning of insurance markets. If so, policymakers would have only three ways to respond. First, they could fund the subsidies by allowing the deficit to increase. Second, they could approve additional spending cuts and tax increases to augment the pool of resources available to fund the subsidies. Finally, they could scale back the program either by changing the standard benefit package to reduce premiums or by trimming the generosity of the subsidies.

This third approach, which may appear to be the obvious response, could be problematic; it provides a good illustration of the problems and difficulties that one encounters when modifications are made in comprehensive health proposals. Often, ad hoc adjustments designed to reduce costs in one area interact with other components to raise costs elsewhere in the proposal. For example, if the commission increased the cost-sharing requirements for the standard benefit package in an effort to reduce premiums and, hence, premium subsidies, it would find that net federal costs would be reduced little because there would be a concomitant increase in the spending for the cost-sharing subsidies that are paid for people with income below 200 percent of poverty. Alternatively, if the commission tried to reduce premiums by narrowing the range of services covered in the standard benefit package, it would soon discover that much of the savings achieved from lower premium and cost-sharing subsidies was offset by increased federal costs for the wraparound benefits available to people below the poverty level. Thus, under the proposal, lowering federal subsidy costs by reducing premiums is, at best, a "two steps forward, one step back" process.

In formulating an alternative that permitted full funding of subsidies from the pool of resources generated by the proposal, CBO found that it had to alter the proposal's subsidy structure in addition to scaling back premiums by limiting the benefit package. This route was taken because CBO concluded, after discussions with health insurance actuaries, that the level of premiums consistent with fully funding the subsidies using the pool of resources specified in the proposal would be insufficient to purchase what most would regard as a minimally adequate package of benefits. Accordingly, the premium constraint was achieved with a fairly Spartan benefit package and the elimination of the cost-sharing subsidies called for in the proposal for people with income between 100 percent and 200 percent of the poverty level.

There would be many ramifications for the health care system and the people it serves if covered benefits and subsidies were reduced to this degree. More people--mostly in income ranges between 100 percent and 200 percent of the poverty level--might purchase health insurance in response to lower premiums. But some others might be discouraged from purchasing because the benefit package would be lean and they would have no cost-sharing assistance. (People with income below poverty would not be affected at all because they would make up in wraparound benefits what they lost in standard coverage.) Others who could afford to do so would probably purchase supplementary insurance for benefits not covered by the standard package; they would generally have to pay for additional coverage out of after-tax income, which would enhance their cost-consciousness. The resulting health care system might provide quite comprehensive coverage for both poor and relatively well-to-do families, and rather meager benefits for those with moderate income.

Effects of the Proposal on Employers and Employees in Certain Firms

Although employers would only be required to offer--not to pay for--health insurance coverage for their employees, many could find their circumstances altered considerably under this proposal and not always for the better. Ultimately, however, those faced with higher costs for health care would pass them on to their employees through lower wages.

Depending on the standard benefit package specified by the Health Care Standards Commission, some small firms that currently offer health insurance to their employees might face considerably higher premiums under the proposed system. If the benefit package resembled CBO's more comprehensive option, voluntary participation and community rating in the HPPC could cause premiums to be significantly higher for those firms that currently have healthy employees and low, experience-rated premiums. They would also tend to be higher for firms whose current benefits were less generous than those in the standard benefit package. By contrast, with a less comprehensive benefit package, experience-rated firms with healthy employees might face similar or higher premiums for less generous coverage than they currently have. Moreover, if AHPs in the HPPC experienced significant shortfalls in premiums and subsidies for low-income people, all small firms might face increases in premiums the next year. To the extent that healthier workers chose to drop their coverage in the face of rising premiums, adverse risk selection in the HPPC pool would become more severe.

Some large employers--who would have to obtain their plans outside the HPPC--might also consider themselves to be "losers" under the proposed system in the short run. In particular, those that did not intend to pay for their employees' health care coverage might, nonetheless, find themselves involuntarily contributing to such coverage. This situation could occur because some large firms might not be able to obtain insurance coverage in the non-HPPC market for a price equal to or below the reference premium although they would be required to offer their employees a plan that was no more expensive than that amount.[1]

The firms most likely to be confronting this problem would be those just slightly larger than the size cutoff for mandatory participation in the HPPC (generally 100 employees) that did not contribute to the cost of their employees' coverage. With many workers in these firms choosing coverage through a spouse who worked for a firm that contributed to employees' insurance costs, the firm's actual insurance pool could be well under 100. Such firms might face relatively high premiums if they had even a few participants in their plan with health problems. Thus, although in theory firms would only be required to offer, not to pay for, coverage, some firms might have to make some contribution to satisfy the requirement that the premium be no higher than the reference premium in the HPPC. In

1. This provision, which would generally apply for each type of enrollment and age group of the principal enrollee, would be modified for closed AHPs that elected to use community rating across types of enrollment or HPPC areas.

the end, those payments would be passed on to workers in the form of lower wages.

Under the circumstances just described, an inequitable anomaly would occur. Although the firm would be contracting to obtain the cheapest possible AHP for its workers, the workers would have to pay taxes on a portion of their contributions for health insurance. This situation, which would never face an individual who chose the cheapest available plan in a HPPC, would arise because the tax-exempt amount of premiums paid by both the employer and enrollee could not exceed the HPPC's reference premium.

Effect of Cost-Sharing Provisions and Alternative Benefit Packages on AHPs of Different Types

Advocates of the managed competition approach assume that one of the consequences of a more competitive marketplace would be that more people would enroll in health maintenance organizations (HMOs). Some of the provisions of the proposal would have major consequences for HMOs and might affect in unforeseen ways their ability to compete.

Cost-Sharing Provisions

The basic tenet of the managed competition approach is that all health plans should offer a standard benefit package. Opinions differ, however, on whether that package should encompass standardized cost-sharing amounts. Advocates for standardizing cost sharing, which is the approach adopted in the proposal, maintain that such standardization is necessary if consumers are to be able to compare premiums among plans and make informed choices.[2]

Other observers, however, contend that even under managed competition, two cost-sharing options--one lower and one higher--should be permitted. Their reasoning is that cost sharing plays very different roles in plans of different types. Effective health maintenance organizations, for example, typically have low cost sharing and limit their patients' use of services through careful management. Fee-for-service plans, in contrast, rely on higher cost sharing to control utilization, imposing much less restrictive management on patients. Consumers understand the alternatives they face when selecting a particular type of plan: lower out-of-pocket spending and more restrictions on choice in HMOs versus higher out-of-pocket spending and fewer restrictions on choice in fee-for-service plans.

Given the different functions of cost sharing in different kinds of plans, proposals that would standardize cost sharing across all plans could have very disruptive effects on the health care system, at least for the first few years. If, for example, the standard benefit package required cost-sharing amounts for all plans that were similar to those charged by HMOs today, fee-for-service plans might experience large increases in use of services. The only way for them to compensate for that increased use would be to increase their premiums significantly, which could eventually drive them out of the market.

Conversely, if the standardized cost-sharing amounts reflected current fee-for-service patterns, HMOs could find themselves at a competitive disadvantage, since low cost sharing is the major attraction of HMOs for many of their enrollees. Although HMOs could probably lower their premiums in those circumstances, their ability to do so might be limited by the additional administrative costs imposed by the new cost-sharing provisions. Moreover, it is unclear how consumers would respond to HMOs with lower premiums and higher cost sharing. As a result, the overall effects of the proposal's cost-sharing provisions on the market shares of HMOs and fee-for-service plans are uncertain.

In both of the situations just described, competitive forces would drive those plans that could not survive out of the market, but the transition to a new market structure could be difficult for health plans, providers, and patients alike. To avoid some

2. The proposal actually requires uniform cost sharing for all types of plans, with one exception. Network plans would be required to implement higher levels of cost sharing than the standard amounts for out-of-network use.

of the potentially disruptive consequences of standardized cost sharing, the proposal includes a requirement that cost sharing be set so that utilization rates would not change from their current average level.

Although the appeal of that idea is understandable, how the cost-sharing requirements would be determined in practice and what their effects would be are unclear. Because the majority of the insured population is still in fee-for-service plans, however, the resulting cost-sharing provisions would probably be closer to those of current fee-for-service plans than to those of HMOs. Thus, although all types of plans would have to adjust to the new cost-sharing structure, the consequences might be more far-reaching for HMOs. The extent to which they could regain their competitive position through lower premiums would depend on the form that the additional cost sharing took, the effects on administrative costs, and the response of consumers to the new payment requirements. There appears to be no guarantee that the proposal's provision of a constant rate of utilization would ensure a smooth transition to a new market structure.

Alternative Benefit Packages

Another important characteristic of HMOs is their relatively comprehensive benefits, which generally emphasize preventive health care. A meager standard benefit package could, therefore, limit the effective functioning of HMOs. The impact would depend on the particular benefits that were or were not covered and the extent to which people purchased supplementary policies for uncovered benefits.

From an HMO's perspective, the most serious deficit in coverage would probably result from limits on preventive health services. Although the less comprehensive package used in CBO's cost estimate does not include coverage of those services, the commission would face tremendous pressure to include them. To cover preventive health care and not allow the subsidies to rise, however, would require even stiffer reductions elsewhere that could erode the typical HMO benefit package in other ways.

Role of the Health Care Standards Commission

The proposal would create a new federal agency, the Health Care Standards Commission, which would have major responsibilities for almost every component of the health care system, eclipsing the role of the states and in some cases that of other federal agencies. As described in Chapter 1, those responsibilities would be exceptionally broad, ranging from setting national program standards to implementing nationwide subsidy programs. Could a single centralized federal agency perform all of the diverse functions of the commission effectively, and could an appointed body withstand the many political pressures the commission would face?

The tasks that might be fitting responsibilities for a single centralized agency are those that relate to the design and establishment of the proposed new health care system. Examples include specifying the benefit package (including the cost-sharing requirements), developing the factors for adjusting premiums for risk, setting standards for AHPs and HPPCs, establishing information standards, and determining annual federal expenditures for premium and cost-sharing subsidies.[3]

Yet the decisions made in some of those areas would affect the future viability of the health care system and could be highly controversial and politically sensitive. Designing the benefit package is an important case in point. Under the proposal, the commission would basically be faced with a Hobson's choice. It would be told the maximum amount that would be available for subsidies and could design a benefit package that was consistent with that amount. But to ensure full funding of the subsidies, the benefit package would have to be so lean that it would probably be unacceptable to many people. Because the commission would have to ob-

3. Two additional federal boards responsible to the commission would assist in some of those activities. The Benefits, Evaluations, and Data Standards Board would provide advice on benefits, information standards, and the evaluation of health care services. The Health Plan Standards Board would advise the commission on standards for AHPs and HPPCs.

tain Congressional and Presidential approval for its recommendations, limiting the benefit package might be extremely difficult. If it adopted a generous benefit package, however, the subsidy shortfall could cause major disruptions to the health care system.

The commission would also have major responsibilities for the day-to-day operations of the health care system--activities that it might be less capable of undertaking. The commission's functions would include monitoring the HPPCs and the reinsurance market for health plans, determining the eligibility of low-income families for premium and cost-sharing subsidies, distributing those subsidies to health plans, and developing and implementing the system of transfer payments among HPPCs to ensure that premium and cost-sharing adjustments for low-income families were distributed equitably. The commission would also be required to register and oversee all AHPs in the country, including the plans of self-insured firms. (State certification would not be a requirement for registration, which raises the possibility that plans would not have to be licensed in the states in which they operated.)

In addition, the commission would have to ensure that states had established satisfactory protections regarding solvency for enrollees in insured health plans and would itself have to establish solvency protections for enrollees in other plans. To be appropriately responsive to needs and problems at the local level, a federal agency performing these functions would probably need to have regional, state, and local offices across the country. The proposal, however, makes no explicit provisions for such a structure.

Conclusion

Several features of the Managed Competition Act that might otherwise produce unintended consequences, lengthen the time needed for implementation, or limit the effectiveness of the approach could be modified quite simply. One could, for example, allow two alternative cost-sharing structures for AHPs, use a single poverty standard nationwide to set the eligibility criteria for subsidies, and allow low-income people to establish their eligibility for subsidies at local offices (possibly using local offices of the Social Security Administration, or state and local welfare agencies).

Changing other aspects of the proposal that might affect its feasibility could prove more controversial because some of them are inherent elements of the underlying philosophy of the approach. As described in this chapter, for example, allowing voluntary enrollment in AHPs and permitting only those firms with no more than 100 employees to participate in the HPPC would have the potential to produce unstable premiums, especially if federal subsidies were not fully funded. Moreover, without additional revenues or spending cuts, deficit neutrality would be difficult to reconcile with a comprehensive benefit package and full funding of the subsidies.

These problems present difficult choices and trade-offs. The most immediate question, however, concerns the issues that should be resolved now as part of the proposal versus those that should be left to the commission, other government agencies, or the Congress to decide in the future.

Appendix

Illustrative Effects of Shortfalls in Federal Subsidies and Premiums Under the Managed Competition Act

The examples in this appendix illustrate several important characteristics of the Managed Competition Act's premium subsidy system. First, if the federal subsidies were not fully funded, premium shortfalls could be substantial for accountable health plans (AHPs) charging the reference premium as well as for higher-cost plans. Second, AHPs charging more than the reference premium could experience significant shortfalls if they attracted large numbers of low-income enrollees--regardless of whether the subsidies were fully funded. Third, poor families would face rather small out-of-pocket costs if they chose to enroll in higher-cost plans. Finally, the cost of insurance could be substantial for those with income between 100 percent and 200 percent of the poverty level--the income range in which the subsidies would be phased out.

The effects of a shortfall in federal subsidies are illustrated in Table A-1 for an AHP charging the reference premium (assumed to be $2,300 for an individual). Case 1, the simplest situation, assumes that the subsidies are fully funded and that individuals receive no contributions from employers. Because the plan charges the reference premium, it is allowed to charge low-income people the full amount. Individuals with income up to 100 percent of the poverty level receive full subsidies. For individuals with income above the poverty level, the subsidy falls 1 percentage point for every percentage point that their income exceeds the poverty level, reaching zero at 200 percent of the poverty level.

In Case 2, which assumes a federal subsidy percentage of only 70 percent, the amount that plans can charge all low-income people drops, with the reduction being proportional to the amount of the original federal subsidy. In other words, the reduction in the total premium paid to the plan is 30 percent of the full subsidy at each level of income. The enrollee's payment remains the same, and the plan absorbs the shortfall.

Cases 3 and 4 show the effects of contributions from employers, which are assumed to be 80 percent of the reference premium. In both cases, the federal subsidy drops dramatically. In Case 3, which assumes that the subsidies are fully funded, the subsidy becomes zero for individuals with income at 120 percent of the poverty level. With partial funding of the subsidies, the subsidy becomes zero at a lower level of income. In the particular example shown in Case 4, which assumes a federal subsidy percentage of 70 percent and an employer's contribution of 80 percent of the reference premium, there is no subsidy at any income level. (Case 4 also assumes that plans can accept all of an employer's contribution, so that the shortfall in premiums is reduced for low-income enrollees up to the income level at which that contribution equals the premium the plan can charge--which is at 133 percent of the poverty threshold in this example.)

Under the proposal, plans charging more than the reference premium would have to lower their premiums for low-income people, regardless of

Table A-1.
Shortfalls in Federal Subsidies for an AHP Charging the Reference Premium (In dollars)

	Payment (By income, as a percentage of the poverty level)			
	100	120	150	175
Case 1: Federal Subsidy Percentage = 100 Employer's Contribution = 0				
Actual Premium	2,300	2,300	2,300	2,300
Premium AHP Could Charge	2,300	2,300	2,300	2,300
Employer's Payment	0	0	0	0
Federal Subsidy Payment	2,300	1,840	1,150	575
Enrollee's Payment	0	460	1,150	1,725
Premium Shortfall	0	0	0	0
Case 2: Federal Subsidy Percentage = 70 Employer's Contribution = 0				
Actual Premium	2,300	2,300	2,300	2,300
Premium AHP Could Charge	1,610	1,748	1,955	2,128
Employer's Payment	0	0	0	0
Federal Subsidy Payment	1,610	1,288	805	403
Enrollee's Payment	0	460	1,150	1,725
Premium Shortfall	690	552	345	173
Case 3: Federal Subsidy Percentage = 100 Employer's Contribution = 0.8 x 2,300 = 1,840				
Actual Premium	2,300	2,300	2,300	2,300
Premium AHP Could Charge	2,300	2,300	2,300	2,300
Employer's Payment	1,840	1,840	1,840	1,840
Federal Subsidy Payment	460	0	0	0
Enrollee's Payment	0	460	460	460
Premium Shortfall	0	0	0	0
Case 4: Federal Subsidy Percentage = 70 Employer's Contribution = 0.8 x 2,300 = 1,840				
Actual Premium	2,300	2,300	2,300	2,300
Premium AHP Could Charge	1,610	1,748	1,955	2,128
Employer's Payment	1,840 [a]	1,840 [a]	1,840	1,840
Federal Subsidy Payment	0	0	0	0
Enrollee's Payment	0	0	115	288
Premium Shortfall	460 [a]	460 [a]	345	173

SOURCE: Congressional Budget Office.

NOTES: The reference premium is assumed to be $2,300 for a single individual.

AHP = accountable health plan.

a. The proposal does not address the situation in which an employer's contribution is greater than the amount that the AHP is allowed to charge. In this example, CBO assumes that the employer pays, and the plan can keep, the employer's full contribution.

whether the subsidies were fully funded. The effects of this provision are shown in Table A-2 for a plan charging $2,500 for an individual policy with a reference premium of $2,300. In Case 1, which assumes full funding of the subsidies, the shortfall in premiums reflects only the consequences of the plan's premium being above the reference premium. In Case 2, the premium shortfalls are the result of the combined effects of a 70 percent federal subsidy and the plan's premium being above the reference premium. Consequently, in this example, which assumes no contributions from employers, the shortfalls in Case 2 are more than four times as large as the shortfalls in Case 1.

Table A-2.
Shortfalls in Premiums and Federal Subsidies for an AHP Charging More Than the Reference Premium

	Payment (By income, as a percentage of the poverty level)			
	100	120	150	175
Case 1: Federal Subsidy Percentage = 100 Employer's Contribution = 0				
Actual Premium	2,500	2,500	2,500	2,500
Premium AHP Could Charge	2,320	2,340	2,400	2,450
Employer's Payment	0	0	0	0
Federal Subsidy Payment	2,300	1,840	1,150	575
Enrollee's Payment	20	500	1,250	1,875
Premium Shortfall	180	160	100	50
Case 2: Federal Subsidy Percentage = 70 Employer's Contribution = 0				
Actual Premium	2,500	2,500	2,500	2,500
Premium AHP Could Charge	1,630	1,788	2,055	2,278
Employer's Payment	0	0	0	0
Federal Subsidy Payment	1,610	1,288	805	403
Enrollee's Payment	20	500	1,250	1,875
Premium Shortfall	870	712	445	223

SOURCE: Congressional Budget Office.

NOTES: The reference premium is assumed to be $2,300 for a single individual; the actual premium is assumed to be $2,500.

AHP = accountable health plan.

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